FLORIDA HOSPITAL EAST ORLANDO

PROGRAM MANUAL

Department of Medical Education
Family Medicine
2018-2019

TABLE OF CONTENTS

Title Page 1

Manual Acknowledgement 8

Osteopathic Oath 9

AOA Code of Ethics 9

PART I: General Information 12

Introduction from the director of Medical Education 13

Mission Statement 14

GME Directory & Medical Education StaFF 14

Department of Medical Education 14

Leadership 14

Family Medicine Core Faculty 14

Florida Hospital East Orlando Medical Education Staff 15

Florida Hospital Graduate Medical Education Manual 15

Resident Association 15

Residency Program 16

Program Descriptions 16

Educational Goals of the Program 16

ACGME Skills and Competencies of the Graduating Resident 16

COMLEX Level 3 19

Florida State Licensure 19

Continuing Medical Education Requirements for Licensure 19

CME Requirements for *FIRST* renewal 20
CME Requirements for *Subsequent* Renewals 20
PART II: Resident Benefits **21**
Professional memberships *22*
Malpractice *22*
Health Coverage and Medical Reimbursement *22*
Meals *23*
Parking *23*
Lab Coats *23*
Call rooms *23*
Counseling Support *24*
Library Access *24*
PART III: Resident Eligibility and Promotion **25**
Interview Eligibility Criteria – Osteopathic Family Medicine Residency *26*
Resident Selection Policy And Procedures *26*
Criteria for advancement and promotion of residents *27*
Advancement Specifics *28*
Graduation *29*
Chief Residents & Class REpresentatives *29*
Compensation 30
Class Representatives 30
PART IV: Family Medicine Residency **31**
Family Medicine Residency Components *32*
I. Continuity of Care 32
II. Family Medicine Residency Training Services 32
A. Family Medicine Residency Services (FMRS) 32
B. Pediatric clinics and inpatient service 32

C. OB/GYN Service 32
III. Clinical Rotations 33
Osteopathic FM –Rotation Curriculum 2017-2018 .... *33*
IV. Didactics 34
Family Medicine Resident Lectures 34
Journal Club 34
Case Review 34
ACOFP Resident Requirements *34*
Family Medicine Checklist *35*
Patient Encounters 35
Procedures 35
Procedure Check Offs 36
Number of continuity clinics 36
Part VI: Scholarly Activity 37
Research Credentialing 38
Continuous Quality Improvement 38
PART VII: POLICIES and Procedures 39
General Resident Expectations *40*
Advisor and Advisee meetings with mentoring form *40*
Program Director Meetings *40*
Rotation Documentation *40*
Evaluation *41*
Resident Supervision *41*
DEFINITION OF TERMS: 41
Levels of Resident Supervision by Attending Physician 42
Supervision of the resident in the Outpatient Setting 42
Supervision of the resident in the Inpatient Setting by Core Faculty 42

Resident Competence and Progressive Responsibility 43
Counseling *43*
Procedure – Counseling 44
Clinical Competency Committee Policy 45
Rotation Failure *46*
Grievances *47*
Transition of Care Policy 47
Outpatient setting 47
Inpatient Setting 47
Telephone Call responsibilities *48*
Illness *48*
Leave *49*
Personal Leave 49
Professional conference attendance and continuing medical education 51
Maternity/Paternity/adoption Leave 51
Bereavement Leave 51
Mission Trip 51
Interviews 51
Call *51*
Ambulatory Off-hours Call 51
FMRS Call 51
OMM 52
Geriatrics 52
Assignment Swaping *52*
Call Swap 53
Rotation Swap 53
Shift Swap 53

Clinic Swap ... 53

Elective Rotations ... *53*

Away Rotation ... *53*

certification ... *54*

Online Modules ... *54*

Tumor Board ... *54*

Committee membership ... *54*

Duty Hours ... *54*

Duty Hours Oversight ... 55

Moonlighting ... *55*

Volunteering ... *55*

Stress, Fatigue and Impairment Policy ... *55*

Stress & Fatigue ... 55

Counseling Support ... *55*

Fatigue management and Mitigation ... 56

Work Environment ... *56*

Residents who are unfit for duty or do not call/do not show for duty ... 57

Reimbursement Policy ... *57*

Disaster Plan & Mass Casualty ... *59*

PART VIII: Evaluation Documents ... 60

Part XI: Center for Family Care Specific Policies ... 61

Continuity of Care Clinic – Center for Family Care ... *61*

Synposis ... 61

Goals & Objectives ... 61

Goals ... 61

Objectives ... 62

Clinic Hours of Operation: ... *62*

Resident Responsibilities to CFC *62*
Precepting 64
Test Results (Labs/X-Rays/Reports) 64
MVA/Workers Compensation 64
Controlled Substances 65
911 Referrals 66
Electronic Medical Record (EMR) 66
Clinic Teams 66
Chart Completion 67
Policy for treating CFC staff 67
Video monitoring 67

MANUAL ACKNOWLEDGEMENT

I, ___________________________________ acknowledge that I have

Print Name

Received a copy of the 2016- 2017 FHEO Program Manual, The Florida Hospital Graduate Medical Education Manual, and the AOA Code of Ethics on ____________(date) and acknowledge I have read and understood the contents.

____

Signature of Resident

____

Date

NOTE: This signed acknowledgment is due in Medical Education by the end of Orientation and annually.

OSTEOPATHIC OATH

I do hereby affirm my loyalty to the profession I am about to enter. I will be mindful always of my great responsibility to preserve the health and the life of my patients, to retain their confidence and respect both as a physician and a friend who will guard their secrets with scrupulous honor and fidelity, to perform faithfully my professional duties, to employ only those recognized methods of treatment consistent with good judgment and with my skill and ability, keeping in mind always nature's laws and the body's inherent capacity for recovery.

I will be ever vigilant in aiding in the general welfare of the community, sustaining its laws and institutions, not engaging in those practices which will in any way bring shame or discredit upon myself or my profession. I will give no drugs for deadly purposes to any person, though it be asked of me.

I will endeavor to work in accord with my colleagues in a spirit of progressive cooperation and never by word or by act cast imputations upon them or their rightful practices.

I will look with respect and esteem upon all those who have taught me my art. To my college I will be loyal and strive always for its best interests and for the interests of the students who will come after me. I will be ever alert to further the application of basic biologic truths to the healing arts and to develop the principles of osteopathy which were first enunciated by Andrew Taylor Still.

AOA CODE OF ETHICS

The American Osteopathic Association has formulated this Code to guide its member physicians in their professional lives. The standards presented are designed to address the osteopathic physician's ethical and professional responsibilities to patients, to society, to the AOA, to others involved in health care and to self.

Further, the American Osteopathic Association has adopted the position that physicians should play a major role in the development and instruction of medical ethics.

Section 1. The physician shall keep in confidence whatever she/he may learn about a patient in the discharge of professional duties. Information shall be divulged by the physician when required by law or when authorized by the patient.

Section 2. The physician shall give a candid account of the patient's condition to the patient or to those responsible for the patient's care.

Section 3. A physician-patient relationship must be founded on mutual trust, cooperation, and respect. The patient, therefore, must have complete freedom to choose her/his physician. The physician must have complete freedom to choose patients whom she/he will serve. However, the physician should not refuse to accept patients for reasons of discrimination, including, but not limited to, the patient's race, creed, color, sex, national origin, sexual orientation, gender identity or handicap. In emergencies, a physician should make her/his services available.

Section 4. A physician is never justified in abandoning a patient. The physician shall give due notice to a patient or to those responsible for the patient's care when she/he withdraws from the case so that another physician may be engaged.

Section 5. A physician shall practice in accordance with the body of systematized and scientific knowledge related to the healing arts. A physician shall maintain competence in such systematized and scientific knowledge through study and clinical applications.

Section 6. The osteopathic medical profession has an obligation to society to maintain its high standards and, therefore, to continuously regulate itself. A substantial part of such regulation is due to the efforts and influence of the recognized local, state and national associations representing the osteopathic medical profession. A physician should maintain membership in and actively support such associations and abide by their rules and regulations.

Section 7. Under the law a physician may advertise, but no physician shall advertise or solicit patients directly or indirectly through the use of matters or activities which are false or misleading.

Section 8. A physician shall not hold forth or indicate possession of any degree recognized as the basis for licensure to practice the healing arts unless he is actually licensed on the basis of that degree in the state in which she/he practices. A physician shall designate her/his osteopathic school of practice in all professional uses of her/his name. Indications of specialty practice, membership in professional societies, and related matters shall be governed by rules promulgated by the American Osteopathic Association.

Section 9. A physician should not hesitate to seek consultation whenever she/he believes it advisable for the care of the patient.

Section 10. In any dispute between or among physicians involving ethical or organizational matters, the matter in controversy should first be referred to the appropriate arbitrating bodies of the profession.

Section 11. In any dispute between or among physicians regarding the diagnosis and treatment of a patient, the attending physician has the responsibility for final decisions, consistent with any applicable hospital rules or regulations.

Section 12. Any fee charged by a physician shall compensate the physician for services actually rendered. There shall be no division of professional fees for referrals of patients.

Section 13. A physician shall respect the law. When necessary a physician shall attempt to help to formulate the law by all proper means in order to improve patient care and public health.

Section 14. In addition to adhering to the foregoing ethical standards, a physician shall recognize a responsibility to participate in community activities and services.

Section 15. It is considered sexual misconduct for a physician to have sexual contact with any current patient whom the physician has interviewed and/or upon whom a medical or surgical procedure has been performed.

Section 16. Sexual harassment by a physician is considered unethical. Sexual harassment is defined as physical or verbal intimation of a sexual nature involving a colleague or subordinate in the workplace or academic setting, when such conduct creates an unreasonable, intimidating, hostile or offensive workplace or academic setting.

Section 17. From time to time, industry may provide some AOA members with gifts as an inducement to use their products or services. Members who use these products and services as a result of these gifts, rather than simply for the betterment of their patients and the improvement of the care rendered in their practices, shall be considered to have acted in an unethical manner.

SECTION 18. A physician shall not intentionally misrepresent himself/herself or his/her research work in any way.

SECTION 19. When participating in research, a physician shall follow the current laws, regulations and standards of the United States or, if the research is conducted outside the United States, the laws, regulations and standards applicable to research in the nation where the research is conducted. This standard shall apply for physician involvement in research at any level and degree of responsibility, including, but not limited to, research, design, funding, participation either as examining and/or treating provider, supervision of other staff in their research, analysis of data and publication of results in any form for any purpose.

PART I: GENERAL INFORMATION

INTRODUCTION FROM THE DIRECTOR OF MEDICAL EDUCATION

In line with the osteopathic philosophy which states that we are more than the sum of our parts, Florida Hospital's mission is to extend its healing ministry to the body, mind and spirit. The founders of Florida Hospital believed, as we do today, that a person's physical health is closely linked with his/her spiritual, emotional and mental well-being; and they sought to provide a place where each of these aspects of the whole person could be healed and nurtured.

Today, more than 105 years since it opened its doors, Florida Hospital is committed to these same goals, providing excellent medical care through state-of-the-art service, equipment and training.

As a result, the Family Medicine and NMM Residency Programs at Florida Hospital East Orlando offer the opportunity to provide high quality, comprehensive medical care for the whole person.

This manual will acquaint you with our residency programs. It is important that all Residents review these pages and ask the Department of Medical Education Staff, or myself, any questions you may have.

Brian Browning, D.O.

Director of Medical Education for Osteopathic Programs
Florida Hospital

MISSION STATEMENT

We are committed to teaching and advancing family medicine and osteopathic neuromusculoskeletal medicine while providing compassionate whole person care to the community.

GME DIRECTORY & MEDICAL EDUCATION STAFF

DEPARTMENT OF MEDICAL EDUCATION

Florida Hospital East Orlando
Medical Office Building (MOB)
7975 Lake Underhill Road, Suite 210
Orlando, Florida 32822
Phone: (407) 303-8683
Fax: (407) 303-8659

LEADERSHIP

Chief Academic Officer – Joseph Portoghese, MD

Osteopathic Director of Medical Education – Brian Browning, DO

Family Medicine Program Director – Brian Browning, DO

Neuromusculoskeletal Medicine Program Director – Brian Browning, DO

Family Medicine Residency Associate Program Director – Kamini Geer, MD

Associate Director of Internal Medicine - Naz Gandikal, DO

Medical Director Center for Family Care – Edward Jackson, MD

FAMILY MEDICINE CORE FACULTY

Brian Browning, DO, DME Family Medicine and Neuromusculoskeletal Medicine, FM & NMM Program Director

Eileen Conaway, DO, Family Medicine and Neuromusculoskeletal Medicine

Pallavi Deliwala, MD, Pediatrics

Naz Gandikal, DO, Associate Director of Hospitalists

Kamini Geer, MD, Associate DME, Associate Family Medicine Residency Director

Michael Geisel, PharmD, Pharmacology

Edward Jackson, MD, Family Medicine, Center for Family Care Medical Director

Shing-Yu (Cliff) Lin, MD, Hospitalist

Richard Margaitis, DO, Family Medicine, Neuromusculoskeletal Medicine, Sports Medicine

Arlene O’Donnell, DO, Family Medicine and Neuromusculoskeletal Medicine

Sonia Rico, MD, Pediatrics

Alyaz Somji, DO, Hospitalist

Timothy Spruill, EdD, Psychology

Shawn St.Marie, DO, Hospitalist and Neuromusculoskeletal Medicine

FLORIDA HOSPITAL EAST ORLANDO MEDICAL EDUCATION STAFF

Celina Diaz - Residency Coordinator

Lori Baiji – Department Secretary

Center for Family Care Staff

Kathryn Wilson – Practice Manager

Heather Ciesla – Nurse Manager

Liz Estrada – Assistant Practice Manager

Francis Ando – Department Secretary

FLORIDA HOSPITAL GRADUATE MEDICAL EDUCATION MANUAL

Florida Hospital Graduate Medicine Education has developed policies and procedures that apply to all of its Residency Programs. These policies and procedures can be found in the Florida Hospital Graduate Medicine GME manual. The GME manual can be found on the home page of New Innovations and at www.fhgme.com. Residents should also be familiar with the contents of the GME manual

RESIDENT ASSOCIATION

The Florida Hospital's Resident Association meets several times a year and consists of resident representatives from each Florida Hospital residency program. This association allows residents to express concerns that can be directly brought to the graduate medical education committee.

One senior resident is selected by the program director to be on the resident association. It is expected that this resident will attend all association meetings, unless rotation schedules or vacations do not permit. Prior to the resident association meeting, the resident representative is expected to poll his or her class to determine what issues the residents would like bought to the association.

RESIDENCY PROGRAM

Florida Hospital East Orlando's Family Medicine Residency Program emphasize training Residents in clinical skills, medical knowledge and the physicians' thought processes. This training develops competence through hands-on experiences which stress ambulatory and preventative care.

PROGRAM DESCRIPTIONS

Florida Hospital East Orlando's Family Medicine Residency is designed to address the educational needs of our residents as growing family physicians. Residents care for patients in their Center for Family Care continuity clinics and on the Family Medicine Residency Inpatient Service under the supervision of our full time faculty. Required rotations in specialty and subspecialty areas as determined by the ACGME Family Medicine Program Requirements and AOA program requirements are supervised by specialty physicians who have an interest in teaching and a relationship with the residency program. Elective rotations, determined by the residents to build their skill sets, are also available in several specialty areas. Funds and time are also available for mission trips and Continuing Medical Education Courses. The didactic program consists of informal discussions, morning reports, Jeopardy, Journal Clubs, and formal lecture programs. The program maintains its strong osteopathic identity through dedicated osteopathic lectures, ambulatory clinics and inpatient rounds taught by full time osteopathic faculty.

Detailed information about program structure can be found below.

EDUCATIONAL GOALS OF THE PROGRAM

Florida Hospital East Orlando Family Medicine Residency will provide an environment conducive to education, excellent patient care and research in order to develop osteopathic family physicians that excel in their medical knowledge, clinical practice, professionalism, commitment to life-long learning, and service and leadership in their communities

ACGME SKILLS AND COMPETENCIES OF THE GRADUATING RESIDENT

ACGME Core Competencies are patient care, medical knowledge, systems based practice, practice based learning and improvement, professionalism, and communication. The AOA core competencies are the same as the ACGME core competencies, and in addition include osteopathic philosophy and osteopathic manipulative medicine.

The graduating resident is expected to have the following skills and competencies:

I. Osteopathic Principles

A. Knowledge of Osteopathic Principles, including the four tenets; use of these principles to promote health and wellness and to assess patients with common, complex and/or chronic conditions.

B. Performance of accurate and complete osteopathic structural examinations; and the diagnosis and treatment of somatic dysfunctions.

C. Knowledge of the osteopathic five model concept and application to patient care

D. Documentation of somatic dysfunction and code OMT

E. Incorporating specialty based research to improve osteopathic practice patterns

II. Patient Care

A. Gathering essential information from the patient to develop appropriate diagnostic and therapeutic management plans for acute and chronic conditions across the life span

B. Knowledge of appropriate preventative care and chronic care guidelines; and reconciles these with the needs and resources of the patient and their community

C. Partnering with patients, their families and their communities to promote health, prevent disease, manage chronic conditions and to create patient centered management plans

D. Addressing biopsychosocial implications of acute and chronic disease for patient and family members

E. Performance of specialty appropriate procedures to meet the health care needs of patients, families and communities

F. Ability to counsel patients on procedures performed by other specialties to guide care

G. Caring for patients and families in multiple settings: outpatient, inpatient, postpartum, nursing home, and managing transitions of care between these settings

III. Medical Knowledge

A. Medical knowledge of sufficient breadth and depth to practice family medicine as evidenced by successful completion of COMLEX3, and a scaled score on the ACOFP in-service examinations consistent with passing the certification examination.

B. Ability to assess and act on personal learning needs

C. Application of critical thinking in patient care, including the ability to synthesize information from multiple sources to make clinical decisions

IV. Systems-Based Practice

A. Partners with patients to consistently use health care resources cost effectively and efficiently

B. Ability to develop and implement practice improvement plans

C. Advocates for the patient and the community in the health care system

D. Accepts responsibility as patients' personal physician to coordinate their care and direct care teams to optimize their health

V. Practice Based Learning and Improvement

A. Able to critically evaluate different types of research studies and information received from experts, pharmaceutical representatives, patients, etc.

B. Able to identify gaps in knowledge and create self-directed learning plan to address these gaps

C. Able to use and evaluate point of care evidence based resources

D. Able to identify areas of improvement in clinical practice and create a plan to address these areas

VI. Professionalism

A. Demonstrates honesty, integrity and respect to patients and team members in all encounters

B. Presents himself or herself in a respectful and professional manner

C. Balances physician well-being with patient care needs

D. Completes all clinical and administrative tasks promptly and truthfully

E. Displays a consistent attitude and behavior that conveys acceptance of diverse individuals and groups, including diversity in gender, age, culture, race, religion, disabilities, sexual orientation and gender identity

F. Incorporates patients' beliefs, values and cultural practices in patient care plans

G. Actively seeks feedback and provides constructive feedback to others

VII. Interpersonal and Communication Skills

A. Develops trusting relationships and sustained partnerships with patients, families and communities

B. Engages patients perspectives in shared decisions making

C. Respects patients autonomy

D. Communicates collaboratively with consultants and members of the health care team

COMLEX LEVEL 3

Residents are required to complete COMLEX Level 3 by February of their intern year. Residents who are unable to complete their exam in a timely fashion due to scheduling, must obtain permission from the program director to delay examination. Once scores are received the resident must submit a copy to the program coordinator within 14 days.

If a resident does not pass their COMLEX 3, a meeting is arranged with their faculty advisor to supplement their individualized learning plan with a study plan for COMLEX 3.

FLORIDA STATE LICENSURE

Residents must achieve full Florida Osteopathic License prior to the end of their 2nd year of residency. Until full licensure is achieved, residents must maintain their Florida Training License.

Residents must obtain a valid DEA license prior to graduation.

CONTINUING MEDICAL EDUCATION REQUIREMENTS FOR LICENSURE

Residents are exempt from AOA CME requirements. HOWEVER, the Florida Department of Health Board of Osteopathic Medicine requirements must be met by each resident to obtain and retain a physician's license. **This is extremely important for all fully licensed residents.** (This does not apply to those with a training license only). It is the responsibility of the resident to meet state law, which reads:

For each 6 months of your active, full license that you are in residency you can report 10 hours of CME towards the general requirement per Florida Rule 64B15-13.011. In order to do this, request a letter from GME regarding your status as a resident and training dates. You may then upload the letter and self-report these "live" hours in CE Broker. Be sure to calculate your hours correctly based on 6 month increments of active license with resident status.

Up to 10 hours, per biennium, of CME credit may be fulfilled by performance of pre-approved pro bono medical services.

CME REQUIREMENTS FOR *FIRST* RENEWAL

	Number of Hours Required
General Hours - AOA Category 1A	20
General Hours - AOA or AMA	13
Risk Management - AOA or AMA	1 **
HIV/AIDS - AOA or AMA	1 *
Domestic Violence - AOA or AMA	2 ***
Florida Laws & Rules - AOA or AMA	1 **
Laws regarding the use and abuses of Controlled Substances - AOA or AMA	1 **
Prevention of Medical Errors- AOA or AMA	2 **
Total Hours	40

**Continuing education with regard to Risk Management, Florida Laws & Rules, Controlled Substances, and the Prevention of Medical Errors must be obtained by completion of live, participatory attendance course.

CME REQUIREMENTS FOR *SUBSEQUENT* RENEWALS

	Number of Hours Required
General Hours - AOA Category 1A	20
General Hours - AOA or AMA	14*
Risk Management - AOA or AMA Must be Live/Participatory	1 **
Domestic Violence - AOA or AMA	2 ***
Florida Laws & Rules - AOA or AMA Must be Live/Participatory	1 **
Laws regarding the use and abuses of Controlled Substances - AOA or AMA	1 **
Prevention of Medical Errors- AOA or AMA Must be Live/Participatory	2 **
Total Hours	40

***Two (2) hours of Domestic Violence is required once every third biennium.
* Sixteen (16) hours is required if you have already taken the 2 hours of Domestic Violence.
Domestic Violence: Section 456.031, Florida Statutes was revised in 2006 to require the two-hour domestic violence (DV) course be taken as part of every third biennial re-licensure or re-certification.

The Board generally accepts CME that is approved for credit by either the American Osteopathic Association or the American Medical Association. All credit hours must be earned within the biennium for which they are claimed.

PART II: RESIDENT BENEFITS

PROFESSIONAL MEMBERSHIPS

Family Medicine Residents are required to maintain membership in the following professional organizations:

- American Osteopathic Association
- American College of Osteopathic Family Physicians
- FOMA

These dues will be paid by the Florida Hospital East Orlando Department of Medical Education. Dues renewal notices should be turned into medical education department secretary for payment. The resident is responsible for verifying that payment has been credited to their account.

MALPRACTICE

Please review the Florida Hospital GME manual for the most up to date information.

Per 2016-2017 Florida Hospital GME manual:

The Hospital shall at its own expense add the resident as a participant under the Hospital's professional liability program which shall provide a minimum of one million dollars per incident, three million dollars aggregate on an occurrence basis with no deductible by the resident.

Coverage shall not be available under the Hospital's professional liability program for services performed by the resident outside of assigned Program activities (e.g., when the resident is moonlighting, no coverage is afforded under the Hospital's professional liability program). Elective rotations away from FH will be reviewed with Risk Management and the Office of Graduate Medical Education in order to determine the applicability and/or extent of liability coverage available.

HEALTH COVERAGE AND MEDICAL REIMBURSEMENT

Please review the Florida Hospital GME manual for the most up to date information.

Per 2017-2018 Florida Hospital GME manual:

Health Insurance: The FH Employee Medical Policy is the policy the residency complies with at all times (see FH Employee Handbook). Health insurance coverage for residents and their family will be effective on the first day of orientation. If coverage of a service is excluded, or partially excluded, by the FH Employee Medical Policy, the residency will exclude it as well. Please refer to your benefits package for more information.
Prescription Plan: The FH Prescription Plan (see Employee Handbook) is the policy the residency complies with at all times.
Dental Insurance: Please refer to your Employee Handbook for additional information regarding dental insurance.

MEALS

Breakfast and lunch are made available in the physician lounge(s) at each campus. A $1500 annual meal stipend is included in the resident salary and is divided across resident paychecks to assist with the purchase of food in onsite cafeterias when the physician lounges are closed.

PARKING

The following parking facilities for physicians are available to residents (access requires the use of ID badge):

Orlando campus: located in King Street parking garage 4th floor or higher
East campus: located behind Medical Plaza building and the hospital's cafeteria.
Winter Park: located by the Emergency Department.
Celebration: located past ED second lot.

LAB COATS

Two white lab coats will be furnished to Resident by the Hospital at the beginning of the first year of training to ensure uniformity and identification of Residents. Replacement shall be the responsibility of the Resident. One new coat will be provided at the beginning of each subsequent training year. It is expected that each resident will comply with the hospital dress code to include nametag and appropriate Hospital affiliation identification. Lab coats with insignia or names of other institutions are not to be worn in hospital or while providing any patient care duties. **Residents may not wear lab coats or any FH identification when moonlighting or providing services not related directly to the residency program.**

CALL ROOMS

Safe and secure call rooms are provided for residents on service.

For those residents at the Orlando campus call rooms are located in the basement of the hospital and have been recently renovated to include sleeping quarters, bathrooms/showers, conference room, relaxation/TV area, and dining area.

For residents at the East Orlando campus, call rooms are located on the third floor. Bathrooms and showers are adjacent to these call rooms.

COUNSELING SUPPORT

The faculty psychologist, Dr. Timothy Spruill, is available for support and counseling to residents and their immediate family members.

Additionally, FH has established a complimentary and confidential resource for the Medical Staff called the Center for Physician Well Being, which can be accessed by calling 407.303.9674 or online at http://www.fhphysiciansupportservices.org/. The Center for Physician Well Being provides counseling and psychotherapy for individuals, couples and families, group counseling and psychotherapy, executive coaching, consultation, and physician development.

The Hospital's Employee Assistance Program ('EAP') is also available at no cost to eligible employees, their spouses, and eligible dependents. EAP services include face-to-face counseling, life coaching services (stress management, career planning, financial planning, motivation, time management) webinars, legal services, consultation, referrals and, financial services.

The Employee Assistance program may be accessed by calling 1.800.492.4357. A counselor will conduct a telephonic assessment to determine what services best fit the issue. If a referral to a network provider is necessary, the assessment will include gathering specific provider criteria such as location, day and time availability, and specialty. The network provider will conduct a formal, face-to-face assessment at your first session. The first five sessions are provided free. This assistance is confidential. No information may be shared with anyone else unless the resident gives the counselor or provider written permission to do so. Adventist Health System supports this policy of confidentiality.

Residents are encouraged to alert Dr. Browning, Dr. Geer, Dr. Jackson or Dr. Spruill if they are concerned that a fellow resident or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation or potential for violence.

LIBRARY ACCESS

The Florida Hospital Health Sciences Library, located at Florida Hospital Orlando (601 E. Rollins Street in the basement beside the Barker Conference rooms), contains 1200 books and maintains subscriptions to over 130 Journals. Through Florida Hospital's library and interlibrary loans, access to any published literature available in the United States is possible. A full time librarian is available for assistance. Computer searches of published literature by topic or author are available. Internet access for medical research is provided.

A virtual library through Florida Hospital is available on the Internet at www.floridahospitalmd.org. The medical data resource, Clinical Resource @ Ovid and Up-to-date is provided to each resident through the Internet. In addition, the Nova Southeastern University library is available to all residents.

Electronic library access is provided through the Florida Hospital Medical Library:
https://drupal01.floridahospital.org/medicallibrary/

Additional electronic library access is available through the NOVA OPTI agreement. Request a log in here:
http://www.nova.edu/hpdlibrary/com/form.html

PART III: RESIDENT ELIGIBILITY AND PROMOTION

INTERVIEW ELIGIBILITY CRITERIA – OSTEOPATHIC FAMILY MEDICINE RESIDENCY

Florida Hospital East Orlando will comply with all of the requirements for the basic standards for training. All PGY-1 residents considered for application for Family Medicine Residency training will meet the requirements of the basic standards for residency training in the program and have:

1. Graduated from an AOA Accredited College of Osteopathic Medicine
2. Completed the ERAS application process.
3. Successfully passed COMLEX I and COMLEX II board exams.
4. Acceptable explanation of break in education (if necessary).
5. Commitment to Family Medicine.

Reasons for Ineligibility:

- Applicant does not demonstrate sufficient commitment to the specialty of Family Medicine.
- Applicant did not present favorable impression to faculty and/or resident physicians during elective time spent at Florida Hospital
- Quality of interaction during preliminary contact with staff suggests incompatibility with the Mission and Values of Florida Hospital
- Quality of personal statement, including no obvious commitment to Family Medicine.
- Limited ability to communicate in English, including written and spoken communication

Non-eligible candidates will not be offered an interview or accepted into Florida Hospital Graduate Medical Education residencies.

RESIDENT SELECTION POLICY AND PROCEDURES

1. Applicant must meet all eligibility requirements to qualify for an interview.

2. The requirement for successful completion of the COMLEX II board exam for interview may be waived at the discretion of Program Director.

3. Information about the program is readily available on the program website. https://www.fhgme.com/programs/osteopathic-family-medicine

4. The applicant's file is downloaded from ERAS and is reviewed and screened by the PROGRAM DIRECTOR and Residency Coordinator utilizing the above mentioned eligibility criteria and the following documents:
   a. Personal statement
   b. Transcript score
   c. Dean's Letter
   d. COMLEX scores
   e. Letters of Recommendation

5. This initial screening process will yield applicants who will be granted an interview. These applicants will be contacted via email by the program coordinator to arrange an interview date.

6. The interview process is conducted as follows:
   a. The applicant is advised to report to the Medical Education office at 8:00 AM

b. Informational session about the training program is conducted by the program director and the program coordinator.
c. The PROGRAM DIRECTOR / Program Director, selected faculty and current residents will interview the applicant. Applicants will tour the CFC and FHEO. They will also have an opportunity to meet other faculty and residents.
d. The applicants will have lunch with current residents. This will conclude the interview day.

7. Each interviewer completes an evaluation form and assigns an interview score which includes four areas:
   a. Professional direction
   b. Personal characteristics and interpersonal communication skills
   c. Clinical competence
   d. Overall potential as a resident in our program

8. An overall score is calculated for each applicant based on the sum of the individual interviewer scores. These scores are used to create the initial rank list.

9. The files are also reviewed by the residents at the monthly resident meeting and a resident rank list is created.

10. These rank lists will be reviewed by the selection committee (all faculty, chief intern and chief residents) in mid-late December to create the selection committee rank list.

11. The Program Director or a designee may contact applicants to follow-up and answer any additional questions.

12. The final rank list is created by the Program Director based on the selection committee rank list.

13. The rank list will be submitted to the National Residency Match Program by the Program Director.

14. Applicants that have matched will be contacted and contracts will be sent within 10 working days of the match results.

CRITERIA FOR ADVANCEMENT AND PROMOTION OF RESIDENTS

The decision whether to promote and graduate a resident shall be determined by the Program Director and/or PROGRAM DIRECTOR with the recommendations of the Clinical Competency Committee (CCC) and the faculty. Criteria for advancement shall be based on the seven (7) core competencies. Residents are required to be judged as competent for advancement to each level.

Competencies:

I. **Osteopathic Principles Application –** Demonstrate knowledge and application of the Osteopathic Principles to patient care.

II. **Patient Care** – Family physicians provide accessible, quality, comprehensive, compassionate, continuous, and coordinated care to patients in the context of family and community, not limited by age, gender, disease process, or clinical setting, and by using the biopsychosocial perspective and patient-centered model of care.

III. **Medical Knowledge** – The practice of family medicine demands a broad and deep fund of knowledge to proficiently care for a diverse patient population with undifferentiated health care needs.

IV. **Practice Based Learning and Improvement** – The family physician must demonstrate the ability to investigate and evaluate the care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning.

V. **Communication** - The family physician demonstrates interpersonal and communication skills that foster trust, and result in effective exchange of information and collaboration with patients, their families, health care professionals, and the public.

VI. **Professionalism** – Family physicians share the belief that health care is best organized and delivered in a patient-centered model, emphasizing patient autonomy, shared responsibility, and responsiveness to the needs of diverse populations. Family physicians place the interests of patients first while setting and maintaining high standards of competence and integrity for themselves and their professional colleagues. Professionalization is the developmental process that requires individuals to accept responsibility for learning and maintaining the standards of the discipline, including self-regulating lapses in ethical standards. Family physicians maintain trust by identifying and ethically managing the potential conflicting interests of individual patients, patients' families, society, the medical industry, and their own self-interests.

VII. **Systems-Based Practice** – The stewardship of the family physician helps to ensure high value, high quality, and accessibility in the health care system. The family physician uses his or her role to anticipate and engage in advocacy for improvements to health care systems to maximize patient health.

The methods of evaluation of these core competencies shall consist of direct observation, video monitoring, rotation evaluations, competency check off sheets and written examinations including the annual inservice exam, rotation specific examinations and step 3. These evaluation tools shall be completed by core faculty and outside preceptors. Residents will also be evaluated by their peers, patients, and administrative and nursing staff.

It is expected that residents will complete all resident administrative responsibilities including logs, licensure, and other required paperwork in a timely fashion.
The Clinical Competency Committee (CCC) will use the evaluation methods above to recommend advancement to the next PGY level and graduation to the program director. The program director makes the final advancement and graduation determination.

ADVANCEMENT SPECIFICS

PGY-1 to PGY-2	**PGY-2 to PGY-3**	**PGY-3 to Graduation**
1. Acceptable progress in competencies 2. Able to supervise PGY-1's and students 3. Able to act with limited independence 4. Successfully passed Part III National Boards	1. Acceptable progress in competencies 2. Responsible for independently teaching and supervising junior residents and medical students 3. Increased independence	1. Acceptable progress in competencies. 2. Proficiency in Competencies 3. Capable of practicing independently 4. Able to act and teach independently

GRADUATION

The graduation ceremony will be held in June at a venue determined by the program director and program coordinator.

Please refer to the FH GME manual for further details.

CHIEF RESIDENTS & CLASS REPRESENTATIVES

In April of each year, two chief residents are appointed by the program director for the upcoming academic year. They will serve from May 1 until May 1 of the following year.
Interested candidates are asked to submit their names to the program director.

The following criteria will be considered:

- PGY-3 resident in good academic standing (must have successfully completed COMLEX III, have a Florida medical license and DEA number)
- Demonstrates teaching skills and interest
- Demonstrates leadership and rapport with fellow residents and faculty
- Demonstrates a positive attitude towards the residency program
- Demonstrate strong communication skills

The residents will vote on the candidates and submit their selections to the faculty and the program director. The faculty and the program director will then determine the chief residents, taking into account the selections of the residents.

The Chief residents are expected to:

- Facilitate the educational experience of the residents and medical students
- Be a liaison between the residents, faculty, other Florida Hospital Residency Programs and medical education administration
- Be a resource for problem solving

The responsibilities of the chief residents include:

- Advise the Program Director on issues of importance to the residency
- Attendance at the following committee meetings:
    - FM department meetings
    - Invited to attend monthly CFC business meetings
    - Meet with Office Manager and Medical Director on a regular basis regarding CFC issues.
    - Meet with Program Director every two weeks.
- Oversee residency scheduling
    - Creation of master schedule for the academic year
    - Develop the resident night, weekend, and holiday call schedules
    - Manage any daytime scheduling conflicts for resident coverage which may arise
- Coordinate and oversee Tuesday afternoon Medical Student lectures
- Participate in intern orientation each year
- Assist with resident and faculty interviews

- Assist with attendance and sign-in at lectures
- Assist with audio-visual set up at lectures

COMPENSATION

The chief residents will receive a monthly stipend during the period of their appointment.

CLASS REPRESENTATIVES

The PGY 1 and PGY 2 classes will each elect, with faculty approval, a class representative to assist the Chief Residents in the above endeavors.

PART IV: FAMILY MEDICINE RESIDENCY

FAMILY MEDICINE RESIDENCY COMPONENTS

I. CONTINUITY OF CARE

The focus of the program is the longitudinal primary care experience obtained at the Family Medicine Resident Clinic, Center for Family Care (CFC). The clinic encourages the development of a patient panel for each trainee throughout their residency program. Residents apply the knowledge obtained from other program components to their own panel of patients. Initial visits for a Resident vary: walk-ins, established, old, young, acute, chronic, indigent, insured, Medicaid, Medicare, or managed care patients. Full-time and part-time board certified Family Physicians supervise the care. All patients' medical care is reviewed, discussed, and countersigned by the Attending faculty. Ambulatory training in procedures occurs at the clinic or through specialty supervised consultations. Discussions of clinical and management problems in ambulatory and managed care settings occur when indicated and appropriate. CMS guidelines as it pertains to the teaching program are adhered to closely. Residents also spend time on the inpatient service caring for patients hospitalized from the CFC and the emergency department under the guidance of board certified residency faculty.

II. FAMILY MEDICINE RESIDENCY TRAINING SERVICES

Florida Hospital East Orlando's Family Medicine Residency Program operates three training services:

A. FAMILY MEDICINE RESIDENCY SERVICES (FMRS)

This service admits patients from the continuity of care clinic (CFC), unassigned patients from the Emergency Department and referrals from specific private Family Physicians. Full-time Board Certified faculty Family Physicians and Internists supervise the care which is provided by Family Medicine Residents. Patients are assigned to the Family Medicine Residents from admission to discharge to formulate and direct care. The majority of the patients are discharged into the Residents' panel of patients at the Center for Family Care. The Inpatient faculty direct rounds with discussion of patients admitted to this service.

B. PEDIATRIC CLINICS AND INPATIENT SERVICE

This component provides clinical experience with both inpatient and ambulatory Pediatric patients. Our full time faculty Pediatricians supervise all ambulatory patient care. The ambulatory Pediatric care is provided at CFC. Family Medicine Residents care for the clinic's patients. Inpatient newborn, inpatient pediatrics and the neonatal care experience is at Florida Hospital's Children's Hospital, a part of the South Campus, under the supervision of inpatient pediatric teaching faculty.

C. OB/GYN SERVICE

This component of the program provides clinical, hands-on experience in all aspects of prenatal care, postnatal care, and deliveries. The Florida Hospital OB hospitalists, allopathic residency Family Medicine Faculty and private gynecologists are utilized for this service. Deliveries are performed at Florida Hospital's Women's Hospital, part of

the South Campus. Pathologic PAPs and other gynecological problem cases from the Center for Family Care will be either handled in house or referred to private gynecologists for medical care and training.

III. CLINICAL ROTATIONS

Residents observe and assist Family Physicians and other specialists with the medical care of their patients. Rotations emphasize ambulatory treatment and involvement with inpatient admissions and care where appropriate. Residents will have an opportunity to train with specialists in:

- Dermatology
- Cardiology
- Gastroenterology
- Obstetrics and Gynecology
- Infectious Diseases
- Nephrology
- Neurology
- Ophthalmology
- Orthopedics
- Otolaryngology
- Podiatry
- Pulmonology
- Surgery
- Urology

In an effort to keep all information as up to date as possible, curriculum documents corresponding to each rotation can be found on New Innovations.

OSTEOPATHIC FM –ROTATION CURRICULUM 2017-2018

(AOA and ACGME Compliant)

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IV. DIDACTICS

A comprehensive didactic program is an essential component of the Family Medicine Residency Program. Educational sessions are held each Wednesday afternoon from 12:00 – 5:00 PM. The following core areas are covered: Internal Medicine, OMM, Pediatrics, Women's Health, Behavioral Medicine, Pharmacology, Ortho / Sports Med, Geriatrics, Surgery, Dermatology, Family Medicine, Procedural Workshops, Legal / Practice Management, and EBM workshops. Full-time faculty or invited speakers lead these lectures. Family Medicine Residents are assigned journal club, resident lectures and case presentations as outline below. Additional teaching through formal and informal discussions occurs on rotations and in the clinics.

Didactics are a residency requirement and are blocked time from clinical duties for resident learning. This is not free time for the resident to close charts and run errands. Residents are expected to be on time and stay for the duration of each didactics session. Chief residents track attendance. It is the resident's responsibility to manage their work and notify their attending of their need to leave to in order to arrive on time to didactics. Residents who are late more than 5 times to didactics will have to present for a face to face meeting with the program director to explain their excessive tardiness. Unexcused absence from one or more lectures during didactics will result in the deduction of ½ day of paid leave. In the event that the resident does not have any paid leave remaining, unpaid leave will be assessed and the residency will be extended.

FAMILY MEDICINE RESIDENT LECTURES

Residents will be assigned topics for peer lecture throughout the year. Lectures should be submitted to the faculty assigned as a mentor for that topic at least two weeks prior to the lecture for their review.

JOURNAL CLUB

Journal Club is held once a month. Journal club assignments will be made throughout the year. Residents are required to send the journal article via email to all faculty, residents and students at least two weeks prior to their Journal Club date.

CASE REVIEW

Case reviews will be conducted monthly. Residents may be assigned to present a case in which they were involved. All Patient Safety Organization policies must be followed in these presentations.

ACOFP RESIDENT REQUIREMENTS

Residents must take the annual ACOFP Resident Inservice exam. This is given on site at the residency in October. Scheduling conflicts and excused absences must be pre-arranged with the program director.

All residents must attend a minimum of one national ACOFP Scientific Seminar during PGY-2 / PGY-3. This requirement can be met by the resident attending either the ACOFP Spring Scientific Seminar or the AOA / ACOFP Fall Scientific Seminar. If they attend the Fall AOA Meeting the resident must register as an ACOFP member for the Fall Meeting to count towards this requirement.

Each residency year a *“Resident Annual Report”* and a *“Program Director’s Annual Report”* must be submitted within thirty (30) days following the end of the resident year to the ACOFP.

All residents are required to produce scholarly activities approved by the program director to the ACOFP before or with the final “*Resident Annual Report”*.

All residents must have successfully completed COMLEX Part III in order to receive a contract and advance to PGY-3.

FAMILY MEDICINE CHECKLIST

PATIENT ENCOUNTERS

The following encounters are required for graduation:

- 1650 outpatient encounters in the continuity clinic (CFC)
    - 165 of these encounters in patients 60 years of age and older
    - 165 of these encounter in patients younger than 10 years
    - 150 encounters in the PGY-1 year
- 750 patient encounters dedicated to the care of hospitalized adult
- 250 encounters dedicated to the care of children in the ambulatory setting
- 250 patient encounters dedicated to the care of ill child patients in the hospital and/or emergency setting,
    - At least 75 inpatient encounters
    - At least 75 emergency department encounters
- 40 newborn encounters
- 12 Deliveries
- 250 patient encounters dedicated to care of acutely ill adult patients in in the emergency department

The program can track both inpatient and outpatient encounters. The program cannot track deliveries. Residents must track deliveries in New Innovations as patient logs.
It is also recommended that residents keep records of the above encounters in the event that the data pull needs to be cross checked.

PROCEDURES

The following procedures are required for graduation:

- 10 joint injections
- 5 biopsy of dermal lesions
- 5 excision of subcutaneous lesions
- 3 incision and drainage of abscess
- 3 cyrosurgery of skin
- 2 curettage of skin lesion
- 3 laceration repair
- 2 endometrial biopsy
- 1 colposcopy

- 1 IUD insertion
- 1 IUD removal
- 5 pap smears
- 3 wet mounts
- 3 splinting
- 10 EKG interpretation
- 3 office spirometry
- 2 toenail removal
- 3 defibrillation
- 1 removal of cerumen from ear canal
- 3 endotracheal intubation

The resident is responsible for tracking the above minimum procedures. ALL procedures that the resident performs must be logged in New Innovations. Logs should be updated at the end of each rotation at a minimum. Logs will be reviewed quarterly by the faculty mentor.

PROCEDURE CHECK OFFS

These procedures need to be supervised to ensure competence prior to allowing the resident to perform them without supervision. If you have never been checked-off, you must complete the procedure with an attending present. Check-off's can be done with any attending

- HVLA (cervical spine/thoracic spine/lumbar spine)
- ME
- OCF
- SCS
- MFR
- Trigger point injections
- Neural prolotherapy (if competency desired)
- Knee injection
- Shoulder injection
- PRP/prolotherapy (if competency desired)
- Pelvic Exam

NUMBER OF CONTINUITY CLINICS

Residents must have a minimum of 40 weeks of clinical sessions at the CFC per year

- PGY 1 have 1 half day session per week
- PGY 2 have 3 half day sessions per week
- PGY3 have 3 half day sessions per week

Clinic weeks and half days are tracked by the program.

The number of clinic days per week and the actual day of the clinic may change depending on the rotation. This is done to ensure a rich educational rotation experience.

The resident is responsible for keeping track of their clinic days and should take these requirements into consideration when planning time off and should alert the program director if a problem is foreseen.

PART VI: SCHOLARLY ACTIVITY

Residents are required to complete one scholarly project per specialty in which they will be Board eligible. Activities that meet this requirement include:

- Principle investigator or sub-investigator for a clinical research study
- Oral or poster case presentation at a Regional, State, or National Conference
- Publishable case report
- Publishable literature review / meta-analysis
- Authoring a grant

Residents must adhere to Florida Hospital guidelines when conducting scholarly activity. All projects are subject to approval by the program director, Office of Research Administration, and Institutional Review Board where applicable. Approval forms and instructions can be found on the GME Research website by selecting the project type: www.FHGME.com/research. All projects require a core faculty mentor.

Residents who present at a Regional, State, or National conferences are required to submit their project to the Florida Hospital GME research day as well.

RESEARCH CREDENTIALING

Residents are required to maintain certain research credentials in compliance with the Florida Hospital Office of Research Administration including:

- Collaborative Institutional Training Initiative (CITI) – good for 3 years
    - Biomedical Research
    - Good Clinical Practice
    - Health Information Privacy
- PI Forum
- CV – updated annually
- Financial conflict of interest – updated annually
- IHI certification
    - Once during residency
    - Access code changes regularly
    - Email with instructions sent to you during on boarding
    - Contact GME research office if you do not have this information

*** This list is subject to change

All of the above must be uploaded in the resident's IRBNet.org account. Links and instructions can be found on the GME Research website: www.FHGME.com/research

CONTINUOUS QUALITY IMPROVEMENT

Residents are required to participate in a continuous quality improvement project annually. Teams will be assigned with a mix of PGY level and have a faculty mentor. Projects should be designed to meet aspects of IHI Triple Aim:

1. Improving the patient experience of care (including quality and satisfaction);
2. Improving the health of populations; and
3. Reducing the per capita cost of health care.

PART VII: POLICIES AND PROCEDURES

GENERAL RESIDENT EXPECTATIONS

1. Comply with the policies and procedures set forth in this manual and Florida Hospital Graduate Medical Education Manual
2. Conduct of a professional manner
3. Be on time for all assignments
4. Check and respond to Florida Hospital email daily
5. Check and respond to Athena Inbox daily
6. Arrange coverage of Athena inbox with a team member when away for any period of time
7. Track duty hours and monitor schedule; notify chief resident and program director if a potential problem is identified to prevent violations before they occur
8.

ADVISOR AND ADVISEE MEETINGS WITH MENTORING FORM

All residents are assigned a core faculty advisor for their time in the program.

There are advisor-advisee meetings scheduled four times a year (August, November, February and April). These are the minimum required meeting dates, and more meetings can be scheduled at the discretion of the advisor and advisee.

During these meetings, the FHEO Quarterly Advisor Advisee form should be completed. This form tracks all the requirements for the resident, and allows the development of personal and professional goals through an individualized learning plan.

PROGRAM DIRECTOR MEETINGS

The resident will meet with the program director twice a year to receive feedback on their progress in the program. At the final program director meeting at the end of residency, the program director will provide the summative evaluation.

ROTATION DOCUMENTATION

By the end of each rotation, the resident must complete an attending evaluation and a resident rotation evaluation. All evaluations and procedure logs are to be completed in New Innovations no later than seven (7) working days after the end of each rotation.

Resident procedure logs and patient logs must also be completed. The ACOFP does not accept "no procedure" rotation logs. Procedures performed in the Clinic and/or during moonlighting should be included on procedure logs for that rotation period.

EVALUATION

Resident and Program Evaluations will be continually reviewed by the Clinical Competency and Program Evaluation Committees.

Residents will be evaluated in the following ways:

- Rotation evaluation by preceptor for each rotation (Milestone based)
- Semi-annual performance evaluation (Milestone based)
- Summative evaluation upon completion (Milestone based)
- Annual Inservice exam
- Direct observation
- Video monitoring
- Procedure specific Check Offs
- Outpatient Preceptor Evaluation
- CFC Nursing evaluation
- CFC Administrative staff evaluation
- Junior resident evaluation of senior resident
- Senior resident evaluation of junior resident

Faculty will be evaluated in the following ways:

- Preceptor evaluation by the resident for each rotation
- Annual anonymous faculty evaluation to assess at a minimum:
    - Clinical teaching abilities
    - commitment to the educational program
    - clinical knowledge
    - professionalism
    - scholarly activities

The program will be evaluated in the following ways:

- Annual anonymous resident evaluation of the program
- Annual anonymous faculty evaluation of the program
- Graduate survey

Every completed rotation is evaluated by the resident.

RESIDENT SUPERVISION

DEFINITION OF TERMS:

Attending Physician refers to a member of the medical staff with a faculty appointment.
Program Director refers to a member of the active Medical Staff responsible for overseeing the program and its compliance with ACGME and/or AOA Institutional and program requirements.
Resident refers to an unlicensed or licensed intern, resident, or fellow enrolled in a Hospital post-graduate residency program.

LEVELS OF RESIDENT SUPERVISION BY ATTENDING PHYSICIAN

1. Direct Supervision: The attending physician is physically present with the resident and patient.
2. Indirect Supervision:
    a. with direct supervision immediately available – the attending physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.
    b. with direct supervision available – the attending physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.
    c. Oversight: The attending physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

The attending physician shall provide resident supervision on a graduated basis as the trainee progresses through the training program, based on evaluation of individual knowledge and skill as well as Institutional policy, program and specialty college requirements.

SUPERVISION OF THE RESIDENT IN THE OUTPATIENT SETTING

The Centers for Medicare and Medicaid Programs have established specific protocols for resident supervision. In order to meet these requirements the residents must do the following:

1. The attending physician will directly supervise all PGY-1 residents for every patient for the first year. New PGY-1 residents must see each patient with the attending physician for at least the first six months. After this point, the faculty and program director will determine if the PGY-1 can be graduated to decreased level of supervision by the program faculty. All PGY-1 residents will verbally discuss each case with the attending physician for the entire year. The attending physician will review the notes, clarify any necessary history, and examine the patient. The attending physician will also write a note relating to the visit and the review of the appropriate findings and treatment for all Medicare patients.
2. All senior residents must review their patient cases with their attending physician at the end of each half day clinic session.The exceptions are all Medicare and their associated HMO's, which must be supervised as stated below.
3. All Medicare and/or Medicare HMO patients must be discussed and may be seen by the attending physician supervising the residents. The attending physician must write notes attesting to their direct involvement with the patient's care.
4. All invasive procedures for all patients must be observed, and a chart note completed by the attending physician. As residents become credentialed and more proficient with patient care normally carried out in Family Medicine, the attending physician may only be present for the critical portions of all procedures.
5. All Medicare patients must be seen if OMT is being performed.

SUPERVISION OF THE RESIDENT IN THE INPATIENT SETTING BY CORE FACULTY

The inpatient team consists of a junior resident (PGY-1), a senior resident (PGY-2 or PGY- 3), medical students and the family medicine core hospitalist faculty (attending). The junior resident (PGY – 1) is assigned a set number of patients that are reviewed with senior residents prior to walk or table rounds with the attending. These cases are then reviewed at bedside or during table rounds directly with the attending faculty.

The senior resident (PGY -2/PGY-3) is also assigned a set number of patients that they will see on their own. In addition to this, they will supervise the patient care provided by the junior resident and medical student prior to attending rounds. These patients will then be presented to the attending for supervision either at the bedside or during table rounds.

The Family Medicine Attending is available for direct supervision during work rounds and will review each patient case with the resident team. After work rounds, the attending is available for indirect supervision by phone with direct supervision immediately available during working hours if needed or if there is a change in clinical status. After working hours, the family medicine attending is on call, and is available for indirect supervision with direct supervision available. This ensures attending availability for the inpatient service 24 hours a day and 7 days a week.

Residents are required to call the on call attending in the following cases:
- All ICU admissions
- Any transfers to the ICU
- Any end of life care issues or orders
- Any patients requiring a STAT consultant service (STAT dialysis, STEMI, GI hemorrhage requiring IR)
- Any patient care issues that the intern or senior resident need guidance on

RESIDENT COMPETENCE AND PROGRESSIVE RESPONSIBILITY

The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident as outlined above is determined by the program director and faculty members. The residency program will evaluate each resident's abilities based on specific criteria through the Family Medicine Residency Clinical Competency Committee. The Clinical Competency Committee will evaluate each resident's clinical competence based on his or her progress along residency training milestones of development and certify each resident's ability to proceed to the next graded level of responsibility.

Please refer to GME Policy #1009 Resident Supervision Policy

COUNSELING

When there are sufficient deficits in a resident's performance it is required that all program directors and chairs utilize the resident counseling process.

Counseling is a structured formative process designed to assess, document and supportively correct factors that negatively impact resident performance. Such factors may include, but are not limited to:

- Below average clinical knowledge and skills deficits
- Performance deficits related to anxiety in test-taking, morning reports, teaching rounds, conferences, etc
- Work/life balance issues – i.e. family concerns, work stress
- Cultural adjustments

- Interpersonal and communications skills deficits
- Professionalism
- Work environment factors
- Personal coping deficits

Institutional probation with remediation - Probation with remediation should not to be confused with counseling. Probation with remediation is a separate and resultant action when:

1. A counseling process at the departmental level has not been successful and continuation of the resident in the training program is in jeopardy; or
2. An egregious action or behavioral event has occurred such as (but not limited to):
    a. a serious lack of professionalism
    b. endangerment to the well-being of patients or co-workers
    c. disregard for medical protocol
    d. an illegal action
    e. any other serious and/or willful infraction of hospital policies, procedures and corporate compliance requirements for residents and all employees

This policy should not conflict with, nor replace FH GME's policies on counseling, probation with remediation and resident in good standing.

PROCEDURE – COUNSELING

At the first signs of a performance problem, the program director and/or resident advisor will meet with the resident to identify specific issues and/or behaviors that affect performance and to issue verbal counseling.

If these issues cannot be resolved, the program director or clinical competency chair will initiate a written counseling plan (known as a Focused Academic Counseling Plan):

- a written Focused Academic Counseling Plan will be reviewed and implemented, focusing on the area(s) of deficit
    - the performance deficits will be framed within the AOA/ACGME competencies.
- typical counseling periods are 30-90 days, but may be extended
- the program director, clinical competency committee (CCC), and other faculty will closely supervise, frequently evaluate, and document the progress of the resident in the deficient areas noted in the counseling plan.
- The resident must receive frequent feedback on performance improvement
- The resident will arrange to meet with their faculty mentor weekly for the duration of the Focused Academic Counseling Plan.

After the counseling period is complete, the CCC will review the resident's progress and make a recommendation to the faculty and program director on:

- Whether the academic performance issues have been resolved satisfactorily
- Whether the counseling period will continue
- Whether the resident should be placed on institutional probation with remediation

- Whether continuation in, or reappointment to, the residency program is in jeopardy

The program director will meet with the resident to advise him or her of the recommendations.

Please refer to the FH GME Manual for further policy details regarding resident in good standing, probation with remediation, disciplinary action and dismissal.

CLINICAL COMPETENCY COMMITTEE POLICY

Purpose: To monitor resident performance and adherence to educational, program, and clinical responsibilities; to measure progression of resident performance and skill acquisition along the milestones with recommendations to the Program Director for advancement or learning plans for identified areas of needed improvement

Policy: This policy defines the purpose and responsibilities for monitoring resident progression along the milestones

Each Family Medicine residency program is required to assemble a Clinical Competency Committee. This committee must review all resident evaluations of performance and assessment at least semi-annually; prepare and ensure reporting of Milestone Evaluations on each resident semi-annually to the ACGME; and advise the Program Director regarding resident progress, including promotion, remediation, and dismissal.

The following will further delineate the members of the Clinical Competency Committee and its general responsibilities.

1. Membership
    a. At a minimum, the membership of the committee will be appointed by the Program Director and shall have at least three members of the program faculty
        i. Other members that may attend CCC meetings and provide input include:
            1. Residency coordinators
            2. Clinic administrative staff
    b. The committee Chair may either be appointed by the Program Director or elected from the membership
    c. The degree of participation by the Program Director on this committee is at the discretion of the program
2. Purpose of the committee:
    a. The committee will be responsible for:
        i. ensuring that each resident's performance is reviewed every 6 months
        ii. monitoring the progress of each resident through review of evaluations and performance assessments, including assessment of the Milestones
        iii. reviewing patient panel data (patient encounters as required by the Common Program Requirements for Family Medicine)
        iv. recommending to the Program Director either resident promotion, remediation, or dismissal after comprehensive resident performance review
        v. preparing Individualized Learning Plans for residents requiring remediation of a subcompetency or milestone

vi. preparing Milestone evaluations on each resident semi-annually
vii. ensuring the submission of Milestone evaluations for each resident semi-annually to the ACGME through the WebADS system prior to each deadline
viii. sending aggregate data from resident performance evaluations to the Program Evaluation Committee to include in the annual review process
ix. reviewing the progress of residents on probation, if any, and recommending to the Program Director to lift or continue probation

b. The CCC will monitor patterns in resident performance and send this information to the Program Director and PEC for curricular or systems changes within the program as appropriate
c. The CCC may make recommendations to the Program Director regarding quality, number, frequency, and choice of evaluation tools to ensure adequate evaluation methods are available to measure performance and acquisition of the Milestones
d. The CCC will identify evaluation methods or processes to address gaps in the assessment of resident performance along the Milestones to the Program Director for implementation

3. All Milestone evaluations of resident performance compiled by the CCC will be maintained in their permanent files
4. Schedule:
   a. The CCC will meet initially every month, and may decrease the meeting frequency as milestones are incorporated into the residents evaluations
   b. The CCC must meet semi-annually to provide aggregated performance data to the residents and the ACGME
   c. Ad hoc meetings may be called to address pressing resident issues that may include but are not limited to the following:
      i. Recommendation by the Program Director for any reason
      ii. Consistently low or unsatisfactory evaluation scores
      iii. Consistent lack of adherence to program requirements
      iv. A specific egregious incident for possible probation or dismissal
5. Due Process:
   a. Should a resident disagree with the recommendation of the CCC, the resident must submit a formal appeal in writing to the CCC and the Program Director
   b. The CCC shall follow the institutional Graduate Medical Education Grievance Policy and Due Process Procedure

ROTATION FAILURE

A resident who fails a rotation must meet with the program director and with the program behavioral scientist, Dr. Spruill. The resident must make up the rotation, and it is recommended that he or she use an elective to do this. If a resident decides not to use their elective to make up the failed rotation, he or she will make up the rotation at the end of residency, extending their residency by the amount of time of the failed rotation.

The resident may also be referred to the CCC for counseling.

GRIEVANCES

Please refer to the FH GME manual for the grievance policy.

Residents with a grievance about an individual or the clinical learning environment should first discuss it with their chief residents. If the chief resident is unable to resolve the grievance, or if the grievance is about the chief resident, the resident should discuss it with a faculty member or their faculty advisor. If the faculty member cannot resolve this grievance, or if the grievance is about a faculty member, the resident should discuss it with the program director. All the individuals are expected to handle the grievance in a respectful or confidential manner.

If the program director cannot resolve the grievance, or the grievance is about the program director, the resident can submit the grievance in writing to the GMEC office. The GMEC office handles all grievances in a confidential and respectful manner according to their policy.

TRANSITION OF CARE POLICY

OUTPATIENT SETTING

The primary care resident is expected to be in contact with the hospital team during the course of their patient's hospitalization so they stay abreast of their patient's course and assist the inpatient team in the plan of care.

In the outpatient setting, the primary care resident will communicate with consultants for their primary care patients as needed through phone calls, and/or written reports.

There is an inpatient EMR (Cerner) and an outpatient EMR (Athena) that can be accessed remotely, allowing following of the clinical course of the FMP patient both in the inpatient and outpatient settings.

INPATIENT SETTING

The inpatient service sign outs are scheduled face to face handoffs between the Day team (7 am to 7 pm) and Night team (7 pm to 7 am). All team members are present for sign out unless they have clinic. The supervising attending may oversee team sign out via telephone.

The sign out uses a census data form from the inpatient EHR. The teams reviews the following at each sign out:

- reason for admission
- recent in hospital events
- management,
- medications
- allergies
- code status
- consultants

- tests that need to be followed up

In order to minimize transitions on the day team, the senior residents have a reduced clinic schedule while on FMRS.

TELEPHONE CALL RESPONSIBILITIES

Documentation of the off-hours calls is an important part of Family Medicine. All patient contact via phone must be documented promptly in the EMR. Calls that require direct communication with an attending physician should be routed electronically to an attending. Calls may be routed to other residents and staff as needed when follow up is indicated.

If there are any questions pertaining to the problem(s) being presented, the resident may call the following attendings based on subject matter:

Dr. Browning – Osteopathic and NMM questions

Dr. Geer – Women's Health and OB questions

Pediatric Faculty – Pediatric Questions

Dr. Jackson (medical director) – general medical questions

FMRS attending – inpatient questions

The resident should check New Innovations for coverage details in case the above physicians are unavailable.

Off-hours call coverage is a very important aspect of practice management. All calls, which cannot be managed by phone, do not have to be sent to an emergency room. Some may be seen in the clinic in the morning (Be sure to inform the clinic.). Some may be sent to CentraCare or other urgent care locations. <u>We expect the resident to be accessible and respond according to protocol outline below under the "Call" section of this manual.</u>

ILLNESS

Residents are professionals and are expected to perform their clinical duties as assigned. They are encouraged to practice good personal infection prevention because they will continually encounter patients with contagious illnesses as by the nature of their job. In the event that the resident is sufficiently ill that they are unable to work the procedures outlined below must be followed.

Residents may be asked to furnish proof of illness if they call out of work sick.

If the resident is unable to work their CFC clinic due to illness they must notify *all* the following individuals ASAP via call or text at 6 am:

1. Practice Secretary: Niko (Francis) Ando 321-276-7903
2. Medical Director: Edward A. Jackson, MD 989-928-4946 (in his absence, designee)

If a resident falls ill in the am and is unable to work their afternoon clinic, they must inform the above individuals before 11 am.

If the resident is unable to speak to at least one of the above individuals DIRECTLY or DOES NOT get a response from text, they should contact their Chief resident. If the resident is unable to speak to the chief resident directly, call the Program Director

An email should also be sent to the medical education department secretary (Lori Baiji) and residency coordinator (Celina Diaz) for the purpose of time tracking.

If the resident is unable to work their FMRS shift due to illness they must notify *all* the following individuals ASAP via phone at least one hour prior to the start of clinical duties:

- Chief resident
- Hospitalists on Duty

If the resident is unable to speak to at least one of the above individuals DIRECTLY, they should contact the Program Director.

An email should also be sent to the medical education department secretary and residency coordinator for the purpose of time tracking.

If the resident is unable to work their rotation due to illness they must notify *all* the following individuals ASAP via phone at least one hour prior to the start of clinical duties:

- Rotation preceptor

If the resident is unable to speak to the above individual DIRECTLY, they should contact the Program Director.

An email should also be sent to the medical education department secretary and residency coordinator for the purpose of time tracking.

Missed work will be deducted from paid time off. In the event that no paid time off remains, missed work will be unpaid leave. Unpaid leave may result in extension of the residency program length.

In accordance with Florida Hospital Human Resources Policy, if a resident has 2 or more absences in a 2 month period OR 6 or more absences in a 12 month period, he or she will be required to meet with the program director.

LEAVE

PERSONAL LEAVE

Residents are permitted up to 20 days of leave. This is defined as “working days” which the program defines as Monday – Friday. Residents are scheduled for 10 of their vacation days in advance within the block schedule. The

additional 10 days may be used for personal leave, subject to approval and availability. No more than 5 days of a 2 week rotation, or 10 days of a 4 week rotation may be taken off.

Personal leave must be requested 45 days in advance via the Time Off Request Form. The resident is responsible for obtaining preceptor approval signature. The form MUST be sent via email to Celina Diaz, Celina.Diaz@flhosp.org and Lori Baiji, lori.baiji@flhosp.org.

ONLY EMAILED FORMS ARE ACCEPTED TO ENSURE APPROPRIATE TRACKING.

All requests are subject to approval, so residents should refrain from making plans and travel arrangements until the request has been reviewed and approved. Once time off is approved, the complete form will be returned to the resident and the resident will be marked as off in the outlook calendar.

The current Time Off Request form can be found in New Innovations

Time off is not allowed on the following rotations:

- AR
- FMRS
- Geriatrics
- Newborn
- Nights
- OB
- OMM* *subject to service coverage*
- Pediatrics East
- Pediatric ER
- Pediatrics Inpatient South

Time off is not allowed during the first and last blocks (blocks 1 and 13) of the academic year, regardless of rotation.

Residents may cancel time off requests. Residents may NOT cancel the assigned scheduled vacation time in the block schedule. The cancellation must be emailed to Celina Diaz, Celina.Diaz@flhosp.org and Lori Baiji, lori.baiji@flhosp.org at least 2 WEEKS prior to the requested time off. All time off cancellation request are subject to approval.

MEDICAL AND DENTAL APPOINTMENTS

Residents will not be charged leave time for regularly scheduled medical and dental appointments if arranged in advance. It is expected that once the medical or dental appointment is completed that the resident will return to their rotation.

The resident must submit a time off request for the scheduled **half day** at least two weeks prior to the appointment. On the time off request, there is box for medical/dental appointment which must be checked. The resident must also present a doctor's appointment note within one week of the appointment to the program coordinator, Celina Diaz.

If a doctor's note is not presented, the resident will be charged a half day of personal leave.

PROFESSIONAL CONFERENCE ATTENDANCE AND CONTINUING MEDICAL EDUCATION

Residents are encouraged to seek further education regarding their areas of interest. The AOA allows for a maximum of 20 days away from the program. There is no separate allotment of CME days for conference attendance. Attendance to one ACOFP Annual Conference is required for graduation, therefore no leave days are required for this conference.

MATERNITY/PATERNITY/ADOPTION LEAVE

Please refer to FH GME Manual.

BEREAVEMENT LEAVE

Please refer to FH GME Manual.

MISSION TRIP

Schedule permitting, residents in good standing may be permitted to travel with the residency program on an international mission trip. Further details will be available as trips are planned. Residency sponsored trips do not count against paid time off and are subject to duty hour restrictions. Residents wishing to attend a mission trip will be required to sign a Florida Hospital waiver of liability.

INTERVIEWS

Please refer to FH GME Manual.

CALL

AMBULATORY OFF-HOURS CALL

Clinic call starts at 5:00 p.m. and ends at 8:00 am - Monday through Thursday. Weekend call starts at 5 p.m. Friday until 8 a.m. Monday. The resident covering is responsible for all emergent and urgent calls from CFC patients. The answering service will take messages (per protocol) and contact the resident via service phone. This phone must remain on and in the resident's possession at all times during the hours of call.

Every after-hour call received must be documented as outlined in "Telephone Call Responsibilities" above. FMRS call attendings will back up the resident on call. Faculty and PROGRAM DIRECTOR will provide additional back up call for consultation or to answer questions.

FMRS CALL

While the majority of night shifts in the hospital are covered by the designated night float intern and resident, there does remain some overnight call. The residents on call must carry the FMRS intern/resident service phone, attend to the needs of FMRS and AIMS patients, perform admissions for the FMRS and AIMS services and other courtesy duties as house staff to the hospital. House staff duties may include: death pronouncements of patients whose attending is unavailable, Code Blue response, fall assessments and other urgent/emergent situations regarding patient care. In any instance where the night intern or resident has contact with a patient not on the FMRS or AIMS service, this must be relayed to the patient's attending to ensure appropriate continuity of care and follow up. Interns and residents on night call are required to remain in the hospital at all times.

FMRS call attendings will back up the resident on call. Faculty and the program director will provide additional back up call for consultation or to answer questions.

OMM

This service phone is used to call/page consults from the hospital. It should be shared by all interns and residents on the service. It may be handed over to FMRS at 7PM on Friday and carried by the intern for the weekend, but must be picked up again at 7AM sign-out on Monday. Failure to pick up the pager at 7AM on Monday may be considered a professionalism lapse.

GERIATRICS

The geriatric phone is carried by the resident on geriatric rotation at all times during the rotation. Pages must be answered within 15 mins. Nursing home staff will contact you for orders, lab alerts, emergencies, and to accept new admissions. In the event that there is no resident on geriatric rotation at a given time, this pager will be carried by the resident assigned to AR rotation. All patient issues should be discussed the next day with the Geriatric attending. FMRS call attendings will back up the resident on call. Faculty and PROGRAM DIRECTOR will provide additional back up call for consultation or to answer questions.

In order to provide the resident one day off in seven as per duty hour requirements, the resident must assign the geriatric phone to the FMRS team every week from Saturday 5 pm to Sunday 5 pm. The resident should call the FMRS senior and give sign out on the geriatric patients.

If a resident has to work a random weekend shift on FMRS, he or she should change the geriatrics phone sign out to FMRS to Friday 5pm to Saturday 5 pm. If this is done, the geriatrics attending and the FMRS seniors must be informed.

Please do not give out these phone number out to patients or other parties.

ASSIGNMENT SWAPING

CALL SWAP

Random night calls assigned throughout the year outside of the night float maybe swapped among residents if needed. All call swaps must be approved in advance. The current Call/Clinic Swap form can be located on New Innovations. Care should be taken by the resident that the swap will not result in a duty hour violation prior to seeking approval.

ROTATION SWAP

Due to the complexity of a Residency schedule, rotation swaps are not permitted. Under extreme cases, such as medical leave, a rotation swap may be permitted and is subject to program director approval.

SHIFT SWAP

Residents are expected to work their shift as assigned. When extenuating circumstances exist such as severe illness, death in the family, etc, a shift swap may be permitted and is subject to approval by the program director. The current Call/Clinic Swap form should be used and is located on New Innovations.

Residents who are found to have swapped a shift without permission will have this shift deducted from their paid leave days for failure to work their assignment.

If the resident no longer has unused paid leave, this will result in unpaid leave and extension of residency.

CLINIC SWAP

In effort to maintain continuity of care, swapping clinic is discouraged. This may however be necessary in select cases, such as needing to accommodate the attending's schedule on an elective rotation. This requested clinic swap must be submitted 45 days in advance via the current Call/Clinic Swap form located on New Innovations.

No clinic may be taken off in block 13.

ELECTIVE ROTATIONS

Elective rotations must be authorized. This is done through use of the Elective Request form available on New Innovations. This request form must be completed and submitted to the residency coordinator at least 60 days in advance of the upcoming elective. The program director will review the elective request and inform the resident if the elective has been approved. If an elective request is not submitted 60 days in advance, the resident will be assigned a clinic AR elective.

AWAY ROTATION

Please refer to FH GME Manual.

CERTIFICATION

Residents are expected to maintain as current the following certifications:

- Advanced Cardiac Life Support
- Pediatric Advanced Life Support
- Basic Life Support
- Newborn Resuscitation** only required for interns

ONLINE MODULES

Periodically residents will be required to complete online training modules to meet annual and/or new training requirements. Residents are expected to complete the modules when assigned in a timely fashion and submit certificate of completion to the residency coordinator.

TUMOR BOARD

Residents are encouraged to submit patients to Florida Hospital East Orlando's tumor board. Any cancer patient, inpatient or outpatient, can be submitted to the Tumor Board for review of treatment, prognosis and care recommendations. Residents should attend if their patient is being presented at tumor board. Time is blocked in the outpatient clinic schedule for this learning opportunity.

COMMITTEE MEMBERSHIP

Residents are encouraged to serve on one hospital, GME, or internal residency committee. Residents are encouraged to consider their committee selection and continue with the same committee throughout their residency whenever possible.

DUTY HOURS

Please refer to FHGME manual for ACGME compliant Duty Hour policy.

Resident duty hours will be auto-populated based on rotation assignment in New Innovations. Residents are required to correct and sign off on duty hours for the previous week by 9am every Monday morning. Failure to do so will result in the following:

1. Reminder email
2. If duty hours are not then complete by 9am Tuesday morning the resident will be removed from their rotation to report to the Florida Hospital DIO Dr. Portoghese.

DUTY HOURS OVERSIGHT

Duty hours are reviewed every block. Any resident who exceeds duty hours must meet with the program director to determine the reasons for exceeding duty hours.

Duty hour violation(s) must also be presented by the program director at the Graduate Medical Education Committee meetings to include a reason for the duty hour violation and correction unless related to an exception as stated in the ACGME requirements which requires documentation of exception reviewed and approved by program director

MOONLIGHTING

Please refer to FH GME Manual.

All moonlighting must be approved in advance by the program director and the DIO. The current moonlighting approval form can be found in New Innovations. A new moonlighting request must be submitted by mid-June for the following academic year. Residents must be in good standing to moonlight, possess a full-unrestricted Florida license and DEA, and be covered by malpractice insurance. When a resident is approved for moonlighting and then has a status change to not in good standing, their moonlighting privileges are automatically suspended. Residents on remediation or probation are not allowed to moonlight. Moonlighting hours must be reported as part of the 80-hour work week limit and must be logged accordingly. Interns and J-1 Visa holders are not permitted to moonlight.

VOLUNTEERING

Community service is an important part of the Florida Hospital mission. Residents are encouraged to volunteer in their communities. Clinical volunteering is subject to the same approval process as Moonlighting as above. Clinical volunteering is subject to duty hours and must be logged accordingly.

STRESS, FATIGUE AND IMPAIRMENT POLICY

STRESS & FATIGUE

The program takes the issue of fatigue and stress very seriously. In an effort to combat this national issue, the program has designed a wellness program that all residents participate in. Additionally, faculty and staff vigilantly monitor the residents for signs of stress and fatigue. Residents who identify signs of stress or fatigue in themselves or a coworker should alert the program director and an attending for immediate management assistance.

COUNSELING SUPPORT

The faculty psychologist, Dr. Timothy Spruill, is available for support and counseling to residents and their immediate family members.

Additionally, FH has established a complimentary and confidential resource for the Medical Staff called the Center for Physician Well Being, which can be accessed by calling 407.303.9674 or online at http://www.fhphysiciansupportservices.org/. The Center for Physician Well Being provides counseling and psychotherapy for individuals, couples and families, group counseling and psychotherapy, executive coaching, consultation, and physician development.

The Hospital's Employee Assistance Program ('EAP') is also available at no cost to eligible employees, their spouses, and eligible dependents. EAP services include face-to-face counseling, life coaching services (stress management, career planning, financial planning, motivation, time management) webinars, legal services, consultation, referrals and, financial services.

The Employee Assistance program may be accessed by calling 1.800.492.4357. A counselor will conduct a telephonic assessment to determine what services best fit the issue. If a referral to a network provider is necessary, the assessment will include gathering specific provider criteria such as location, day and time availability, and specialty. The network provider will conduct a formal, face-to-face assessment at your first session. The first five sessions are provided free. This assistance is confidential. No information may be shared with anyone else unless the resident gives the counselor or provider written permission to do so. Adventist Health System supports this policy of confidentiality.

FATIGUE MANAGEMENT AND MITIGATION

Every resident attends an annual lecture on recognizing fatigue and sleep deprivation, and fatigue mitigation techniques.

If clinical care exceeds a resident's ability, the resident is expected to call upon the senior resident on site, the chief resident by phone, the on call inpatient attending, and/or the program director. An arrangement will be made for a resident or attending to assist this resident with clinical duties.

WORK ENVIRONMENT

Florida Hospital East Orlando strives to provide a clinical learning environment that emphasizes:

1. Patient Safety
    a. Residents are educated on reporting, investigating and follow-up of adverse events or near misses
2. Quality Improvement
    a. Residents are educated on quality metrics and quality improvement
    b. Residents are involved in quality improvement projects
3. Supervision and Accountability
    a. Residents are supervised by an attending physician and moved through a gradation of responsibility in patient care and supervision of junior residents
    b. Residents know who their supervising attending is and the role of that attending in the care of the patient
4. Professionalism
    a. Residents are educated on the professional responsibilities of physicians including being fit for duty
    b. Residents are educated on their responsibility to report unsafe conditions and adverse events
    c. Residents are educated that they can report without fear of retribution

5. Well Being

a. Residents are educated on burnout, depression and substance abuse

b. Residents are educated on the in-house programs available to assist those with burnout, depression and substance abuse

RESIDENTS WHO ARE UNFIT FOR DUTY OR DO NOT CALL/DO NOT SHOW FOR DUTY

A resident who presents unfit for duty as determined by the senior resident and/or faculty will be sent home.

A resident who does not show for an assigned duty without following the procedures outlined for calling out sick will be considered a do not call/do not show.

These residents will be required to meet with the program director and with the program behavioral scientist, Dr. Spruill. There will be a make-up call assigned, and it will done for the resident who needed to cover the shift.

These residents may also be referred to the CCC for counseling on professionalism.

REIMBURSEMENT POLICY

The program follows Florida Hospital's reimbursement policy as published in the Payroll website on the Intranet and in the GME manual on New Innovations. Eligible expenses such as membership fees and CME expenditures will be reimbursed up to the allowable extent. Residents are responsible for submitting their request for reimbursement to the program secretary along with supporting documents and original receipts within 30 days of purchase. The resident must then verify and sign the prepared expense report that will be submitted for approval and processing. All funds will be reimbursed through the regular payroll disbursements.

If the resident submits appropriate documentation in advance, such as a bill for membership dues, these items may be payable directly from GME as opposed to the resident submitting payment and then requesting reimbursement. It is the resident's responsibility to verify that submitted payment requests are received and credited by the payee.

Education Allowance

1. FH GME programs provide an education allowance to each resident, distributed in an amount based on a PGY schedule set by program. The education allowance is intended as a benefit that assists in offsetting significant educational costs that individual residents incur. This benefit is paid out in the form of reimbursement for expenses incurred.

2. The Residency Program will reimburse the resident for the following related to the use of education allowance at the discretion of the Program Director.

a. Books, Subscriptions & Learning software

b. Mobile computing devices and other electronics to be used for learning

i. Multiple cell phones. laptop computers, or tablets will not be approved in the same 24-month period.

c. Attendance at local, regional, and/or national conferences or board review courses pertinent to their specialty, and associated travel as defined below.

d. Non-required educational memberships and certifications.

3. The education allowance is issued based on the duration of appointment defined the resident agreement. Unused education allowance does not roll over into the next appointment term. The education allowance for a specified appointment term must be used by the last day of that term, or it will be lost.

Resident Medical License & DEA

1. The Residency Program will pay for a resident's Florida Training Registration (TRN) application fee and initial fingerprinting fee.

2. The Residency Program will reimburse a resident for the following related to unrestricted licenses and DEA:

a. Unrestricted Florida medical license (ME/OS/PO) - reimbursement of unrestricted license fees, initial and renewals, will be prorated based on life of license and time remaining in program from the date in which the license is issued.

i. Prorated amounts will be calculated as:

License Application Fee / Life of License (in months) = Monthly Cost Monthly Cost x Time Remaining in Program (in months) = Reimbursable amount
i.e. $705/24 mos. = $29.38 per month $29.38 * 12 mos. = $352.56 reimbursed.

ii. Program will only reimburse direct license fees; Program will not reimburse for associated fees, including background checks, fingerprinting, notary fees, transcripts, etc.

iii. Additional license costs and fees, not covered by program, are eligible for reimbursement through a resident's education allowance at Program Director discretion.

b. Drug Enforcement Agency (DEA) Certificate – Reimbursement of unrestricted DEA fees, initial and renewals for residents, will be prorated based on the life of the certificate and time remaining in program from date in which certificate is issued.

i. Prorated Amounts will be calculated as:

DEA Application Fee / Life of Certificate (in months) = Monthly Cost Monthly Cost x Time Remaining in Program (in months) = Reimbursable amount
i.e. $731/36 mos. = $20.31 per month $20.31 * 12 mos. = $243.72 reimbursed.

ii. Fellow DEA Certificate fees will be reimbursed in full, by program.

iii. Program will only reimburse direct DEA Certificate fees; Program will not reimburse for associated fees, including background checks, fingerprinting, notary fees, transcripts, etc.

iv. Additional certificate costs and fees, not covered by program, are eligible for reimbursement through a resident's education allowance at Program Director discretion.

Please refer to the FHE GME manual for the full reimbursement policy.

DISASTER PLAN & MASS CASUALTY

Please refer to the FH GME Manual.

PART VIII: EVALUATION DOCUMENTS

In an effort to maintain all forms up to date, all evaluation documents, procedure check off forms, etc, can be found on New Innovations.

PART XI: CENTER FOR FAMILY CARE SPECIFIC POLICIES

CONTINUITY OF CARE CLINIC – CENTER FOR FAMILY CARE

SYNPOSIS

The Center for Family Care serves as the sole continuity clinic for the Family Medicine residency. It serves the community by providing osteopathically focused primary care and neuromusculoskeletal medicine services.

GOALS & OBJECTIVES

GOALS

- Provide family medicine care to the greater Orlando community
- Provide family medicine care to the greater Orlando community

- Provide an environment suitable for residents to learn and grow as physicians as they provide care to the community
- Allow residents to experience providing continuity family medicine care in the outpatient setting

OBJECTIVES

- Provide adequate patient base to expose residents to patients with a variety of pathologies
- Facilitate sufficient patient exposure to allow residents to meet their ACGME/AOA patient encounter and procedural requirements

CLINIC HOURS OF OPERATION:

Morning Half day: 8:00 am – noon
Afternoon half day: 1:00pm – 5:00pm

Residents are expected to be on time and present for those periods and longer if patient care and clinic responsibilities are not completed.

Maximum Number of clinic days per resident year:
PGY-1: ½ day
PGY-2: two ½ days for the first six months of academic year, three ½ days for the remaining six months
PGY-3: three ½ days
PGY-4: three ½ days

Maximum patient volume per half day per resident year

	July to Dec	Jan to June
PGY-1	1 – 5	6
PGY-2	8-9	8- 9
PGY-3	8-9	8-9

Patient volumes are increased per six month period to allow for progressive adjustment to increased patient loads. Residents are required to have a minimum of 40 weeks of continuity clinic per year and should keep this in mind when scheduling vacation that may fall on their clinic day. Due to rotation requirements, continuity clinic assignment may vary. Residents are responsible for verifying their clinic days in Athena at least one week in advance to ensure accuracy.

RESIDENT RESPONSIBILITIES TO CFC

The Center for Family Care (CFC) has a goal of providing quality primary care while training residents in Family Medicine. The Center is dedicated to providing competent and compassionate professional service to our patients. Residents will be evaluated on their communication skills, professionalism and the medical care provided.

Responsibilities include:

- On time arrival at clinic
- Touch base with your MA in the morning so they know you've arrived and discuss any planned procedures or patient issues you foresee, this will allow for a smooth clinic session.
- If you anticipate needing help with a specific patient or procedure, let your attending know prior to the start of clinic as well so that they can help you prepare.
- Document patient education.
- Complete and close all charts of patients with Medicare and Medicare HMO patients within 24 hours
- Complete and close all other charts within 48 hours
- Addend all charts returned by attending for clarification or adjustment within 72 hours.
- Complete all patient forms within 72 hours. *Exception:* *Patients may present for a visit for the sole purpose of form completion, such as FMLA evaluation. These forms should be completed with the patient during their visit.*
- Check ATHENA inbox everyday regardless of rotation.
- Return all patient phone calls within 72 hours.
- Address all refill request within 72 hours.
- Reply to all patient portal messages within 72 hours.
- List the ICD-10 primary diagnosis appropriate for the patient's visit.
- Appropriate evaluation and management (E&M) documentation.
- Follow CPT code protocols and ensure they match the E&M level of service.
- Code every procedure, for example; urinalysis, wet mounts, etc.
- Follow the patient checkout procedures, including the follow up appointment, after visit summary, patient education, and appropriate Rx's and refills.
- Maintain your appointment schedule by knowing your rotations, electives, vacation, etc. - ensuring continuity contact with your patients.
- Discuss all Medicare patients with an attending prior to them leaving the building
- Be flexible, respectful and supportive of the office staff as they provide service for our patients.
- Keep up with your patient schedule to be cognizant of wait times
- Maintain a professional demeanor at all times.
- Maintain the electronic medical record as directed in the Residency documentation training including updating history, problem list, medication list, health maintenance
- **Remain physically in the clinic while your patients are still present**, even if you believe you've completed your portion of the encounter
- Check with your MA at the end of your clinic session to ensure they have all your orders needed for patient specimens
- Review all patients in summary with your attending preceptor at the end of your session

To assist with Clinic workflow we have developed the following organizational system:

COLORS: are used on the Athena screen to indicate patient status

- Orange: Ready for staff to check in
- Blue: With staff for check in
- Light green: Ready for provider
- Dark green: With provider
- Gray: Ready for check out

FLAGS: used outside the exam room door

- Black: Back office order
- Blue: MA or nurse is with patient in the room
- White: Patient is in the room
- Green: Patient is ready for doctor/ back office orders have been completed
- Yellow: Doctor in room
- Red: Patient is ready for discharge, needs an appointment

While we encourage residents to develop their own style as they graduate and enter practice, compliance with the above procedure is required due to the sheer number of different physicians working in the clinic. Standardization has been necessary to allow for timely, efficient patient care.

PRECEPTING

Each resident is assigned to an attending preceptor on the precepting schedule and is expected to precept their patients with that faculty member. However, the resident may precept with any available faculty member as long as that faculty member is not in patient care.

All resident charts must be co-signed by faculty. When residents close their chart they will be prompted to designate a co-signer. The co-signer should be the attending assigned to precept the resident for that clinic session, unless for some reason the patient was precepted with different attending.

TEST RESULTS (LABS/X-RAYS/REPORTS)

Abnormal Results:

Residents are directly responsible to notify their patient(s) of abnormal tests. The patient should be reached by telephone as soon as possible (within 24 hours) if it is an urgent abnormal test. A letter may be sent by the resident if s/he cannot reach the patient by telephone and it is a non-urgent abnormal test. If the phone number is disconnected, wrong number, busy or no answer the resident may ask triage staff for assistance in clinic in obtaining a valid method of contacting the patient. All efforts to contact patients shall be documented in the EMR. If all attempts at contact fail, a certified letter must be sent to the patient's last known address.

Normal Results:

Normal test results may be relayed to patients at scheduled follow up if follow up is timely. They may also be relayed via phone or the patient portal. Alternately a letter stating the normal results may be sent to the patient. Once the letter is composed it can be routed to CFC medical records (Sande Mosteiro) for printing and mailing. All reporting of test results must be documented in the EMR either in an office visit note, telephone encounter or letter.

MVA/WORKERS COMPENSATION

Center for Family Care does not treat work-related accidents or motor vehicle accidents.

1. The physician will instruct the patient to:
    a. Identify and document whether the injury was at work or a motor vehicle accident and where.
    b. Ask and document whether the patient has informed their employer or car insurance about the accident.
    c. Explain that by treating them, it may affect their worker compensation coverage or car insurance coverage. These visits are not covered by private healthcare insurance. The patient may not have current visit, future visits, and all related treatments covered.
    d. Explain that the patient should see a workers compensation physician or car accident physician.
2. All MVA and WC patients seen by a resident shall have an attending physician involved completely with the case including a note documenting their involvement.

CONTROLLED SUBSTANCES

This policy applies to all chronic opiates, benzodiazepines, and stimulants.
Chronic is defined as medication management greater than 90 days

Requirements

1. Signed controlled substance agreement with renewal every 360 days
2. Urine Toxicology Screen at random intervals no longer than 90 days a part
3. No controlled substances may be called in
4. Must be physically seen to get opiate refill
5. May be seen every 90 days for Benzos and stimulants if symptoms are controlled and stable
6. No refills written on prescriptions
7. No future dated prescriptions
8. May write 90 day supply without refill for Benzos or Stimulants in stable patients
9. May leave a monthly prescription up front for Benzos or Stimulants as long as they are seen every 90 days
10. Must transition patient to long acting medications, if unable must document valid reason like allergy, insurance issue, etc.
11. Must include a controlled substance note in your documentation when refill given
12. Must try other treatment regimens outside of controlled substances and document failures
13. Must document imaging and/or records justifying management
14. Must have a Psychiatry referral placed in the record if patient has a coexisting psychiatric diagnosis like depression, anxiety, or other condition

In an effort to combat the nationwide epidemic of opiate overuse and abuse, the Centers for Disease Control and Prevention have issued new chronic pain treatment guidelines. Our clinic will be adopting the guidelines listed below effective July 1, 2016.

- For chronic pain medication treatment for reasons other than cancer and end of life care, we will no longer be prescribing greater than 50 morphine equivalents total per day
- 50 morphine equivalents = 50mg Morphine
50mg Hydrocodone
35mg Oxycodone
20mg Fentanyl
12.5mg Dilaudid
250mg Tramadol
- Any patients who may require more than 50 morphine equivalents will be referred to a Pain Management specialist to obtain their prescriptions
- Opiates for acute pain will not exceed 7 days of 50 morphine equivalents total per day
- Any patient requiring long term opiates will also be prescribed Naloxone, the antidote for an opiate overdose in case of emergency
- We will continue with monthly office visits for refills, regular urine drug screens, and signing controlled substance agreements for patients who receive controlled substances from our clinic who meet the above restrictions
- We will no longer prescribe opiates and benzodiazepines (Xanax, Ativan, Klonopin, Valium) together
- Any patient taking both benzodiazepines with opiates will be offered alternatives to wean off one or both of these medications
- Any patient requiring both long term opiates and benzodiazepines will be referred to a Pain Management specialist and a Psychiatrist to obtain their prescriptions

Physicians at Center for Family Care will not participate in the prescription of low THC medical marijuana.

911 REFERRALS

Please solicit the assistance of an attending prior to calling 911 for emergent transfer of a patient whenever possible. After 911 has been activated, the resident must remain with the patient for safety and in order to relay vital information to the EMS team.

ELECTRONIC MEDICAL RECORD (EMR)

Every patient encounter will be documented in the current EMR. This includes but is not limited to office visits, procedures, phone calls, refill encounters, ambulatory pages. It is your responsibility to keep all medical information secure, accurate, and up to date.

CLINIC TEAMS

Every resident will be assigned to a clinic team. This team will act as a group practice at the Center for Family Care. Each group/team will cover for each other during vacation. Your group members will see your clinic patients when your schedule is full or unavailable. Your goal as a group practice is to maintain continuity of care.

CHART COMPLETION

Timely chart completion and closure is essential for appropriate patient follow-up and for the delivery of high-quality medical care.

1. All Medicare Charts need to be completed/closed within 24 hours of seeing the patient.
2. All other Charts need to be completed/closed within 48 hours of seeing the patient.
3. In-baskets will be reviewed on a regular, on-going basis by an assigned faculty member, who will give a report to the CFC Medical Director.
4. Residents who are not compliant with the above policy will have meetings with the program director and medical director. The resident may also be required to meet with the program behavioral scientist, Dr. Spruill and may be referred to the CCC for counseling.

POLICY FOR TREATING CFC STAFF

CFC staff may be treated by residents and faculty. They will follow the same policies as all other patients in the practice. This applies to scheduling appointments, walk-in sick visits, and medication refills. All encounters must be documented in the current EMR.

VIDEO MONITORING

All residents will be under direct observation with video monitoring as determined by your faculty. Monitoring may not be announced to the resident prior to their clinic. Residents will review the monitoring evaluation with the faculty monitor immediately after their clinic finishes.